DDM North Dakota

Under 21 Continued Stay Review (CSR) Form

Hospital/Facility Name: _____ Phone: _____
Contact Person: _____ Date Sent to DDM: _____
Attending Physician: _____ Admission Date: _____
Estimated Length of Stay: _____ Revised On: _____

Patient Name: _____ Date of Birth: _____ Medicaid Applicant
Social Security #: _____ Medicaid #: _____ ☐ Yes ☐ No
Change in Responsible Party since previous review? ☐ Yes ☐ No (if "yes" complete information below)
Relationship: ☐ Self ☐ Parents ☐ Court ☐ Gov. Agency ☐ Other:
Address: _____ City: _____ State: _____ Zip: _____
Phone: County:

Change in Diagnosis? ☐ Yes ☐ No (if "yes", complete below)
Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: GAF:

Psychiatric Medication Changes? ☐ Yes ☐ No (if "yes", complete below)

Drug Name	Dosage	Purpose	Dates Used

Precautions: _____ Frequency of Checks: _____

Criteria for Continued Stay:

☐ A,B, and C shall be met for admission or continued stay in a psychiatric hospital.

☐ A. Ambulatory care resources available in the community do not meet the treatment needs of the individual. Must meet one of the following:

- ☐ A lower level of care is unsafe, placing recipient at risk for imminent danger/harm.
- ☐ Clinical evidence that lower level of care will not meet recipient's needs.
- ☐ Medically necessary due to complicating concurrent disorders.

Discuss Selection:

DDM Use Only

Meets A? DDM Nurse ☐ Yes ☐ No DDM MD: ☐ Yes ☐ No

Rationale:

 Patient Name:_____

☐ B. Proper treatment of the recipient's psychiatric condition requires services on an inpatient basis under the direction of a physician. Must meet all of the following: either B.1 (psychiatric) B.2 (subtance use).

☐ DSM-IV Diagnosis (excludes chemical abuse or rule-out conditions)

☐ Axis V rating <50

B.1. Psychiatric Criteria

☐ Individual is currently experienceing problems related to the DSM IV Disorder in one of the following categories (circle applicable standards):

a. **Self-care** deficit- due to Axis I impairment placing recipient at risk for self harm
   1. Deficit severe and long standing enough to prevent community setting placement;
   2. Deficit placing the individual in a life threatening physiological imbalance without skilled intervention.

b. **Impaired Safety**- Threat to Self or Others (verbalization or gestures)
Continued suicidal/homicidal ideation with plan of intent and/or continued violent/aggressive behaviors requiring seclusion or restraints.

c. **Impaired Thought Process**- inability ot perceive/validate reality to extent that child cannot negotiate basic enviornment or participate in family/school life.
   1. Disruption of safety to self, family, peer or community group;
   2. Impaired reality testing sufficient to prohibit participation in community educational alternative;
   3. Individual is not responsive to outpatient trial of medicaiton or supportive care;
   4. Individual requires inpatient diagnostic evaluation to determine treatment needs.

d. **Severely Dysfunctional Patterns**- Family, environment, or behavioral processes placing child at risk.
   1. Documentation of family environment escalating symptoms or placing child at risk;
   2. Family situation non-responsive to outpatient or community resources and interventions;
   3. Escalation of instability or disruption;
   4. Severe behavior prohibits participation in lower level of care.

B.2. Subtance Dependence

☐ Experiencing problems with DSM IV disorder in 2 or more of (circle applicable criteria):
   a. Documented signs/symptoms of withdrawal requiring 24 hour medical intervention;
   b. Persistent biomedical conditions/complications in addition to withdrawal;
   c. Emotional/behavioral conditions placing recipient/others at risk.

☐ QMHP has updated plan of treatment, identifying evidence that inpatient services are required.
Describe symptoms/progress from last certified day (Describe specific symptoms/behaviors and dates).

DDM Use Only:

Meets B? DDM Nurse/LCSW ☐ Yes ☐ No DDM MD ☐ Yes ☐ No

Rationale if denial:

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Patient Name:_____

☐ C. The service can reasonably expect to improve the recipient's condition.

Discuss treatment plan goals: dates of plan changes, descripton of changes (update treatment since the last review).

Discuss service intensity since the last certified day (include MD visits, individual therapy, group therapy, family therapy, as well s precautions, seclusion, etc.)

Tentative discharge plans:

Tentative discharge date: _____

DDM Use Only:

Meets C? DDM Nurse/LCSW ☐ Yes ☐ No DDM MD ☐ Yes ☐ No

Rationale if denial:

Completed by Refering Facility:

I affirm that the information provided is a true and accurate description of the above named individual.

_____ _____
Signature Date

DDM Use Only

Approval ☐ No ☐ Yes If yes, specify number of days approved _____

_____ _____
Nurse/LCSW Signature Date

_____ _____
MD Signature Date

Decision effective date: _____ end date: _____